		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0000984

Facility Name: BARTON W. STONE CHRISTIAN HOME

Address: 873 GROVE STREET (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 479-3400 **Fax #** (217) 243-8553

IDPA ID Number: 37-0662538-001

Date of Initial License for Current Owners: 05/15/05

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Russ Bellora **Telephone Number:** (620) 252-0161

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barbara Hannel
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3	122	Intermediate (ICF)	122	44,530	3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	8,760	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,865	5,607		8,472	8
9	SNF/PED					9
10	ICF	15,047	29,275		44,322	10
11	ICF/DD					11
12	SC	725	4,918		5,643	12
13	DD 16 OR LESS					13
14	TOTALS	18,637	39,800		58,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.60%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	507,684	19,457	6,280	533,421		533,421	(17,017)	516,404			1
2	Food Purchase		324,545		324,545	(10,996)	313,549		313,549			2
3	Housekeeping	295,485	31,156		326,641		326,641	(106)	326,535			3
4	Laundry	113,089	25,605		138,694		138,694		138,694			4
5	Heat and Other Utilities			221,759	221,759		221,759	(688)	221,071			5
6	Maintenance	159,924	33,973	52,539	246,436		246,436	(18,694)	227,742			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,076,182	434,736	280,578	1,791,496	(10,996)	1,780,500	(36,505)	1,743,995			8
	B. Health Care and Programs											
9	Medical Director					1,000	1,000		1,000			9
10	Nursing and Medical Records	2,610,625	243,581	45,707	2,899,913	(1,000)	2,898,913	(17,381)	2,881,532			10
10a	Therapy											10a
11	Activities	163,132	1,695	144	164,971	(31,772)	133,199	(1,653)	131,546			11
12	Social Services	130,892	11,312	2,596	144,800		144,800		144,800			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,904,649	256,588	48,447	3,209,684	(31,772)	3,177,912	(19,034)	3,158,878			16
	C. General Administration											
17	Administrative	131,568		297,274	428,842		428,842	(272,375)	156,467			17
18	Directors Fees											18
19	Professional Services			33,887	33,887		33,887	25,183	59,070			19
20	Dues, Fees, Subscriptions & Promotions			16,662	16,662		16,662	1,579	18,241			20
21	Clerical & General Office Expenses	81,882	4,466	53,762	140,110		140,110	145,664	285,774			21
22	Employee Benefits & Payroll Taxes			1,129,422	1,129,422	10,996	1,140,418	37,284	1,177,702			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,850	12,850		12,850	30,446	43,296			24
25	Other Admin. Staff Transportation			3,477	3,477		3,477		3,477			25
26	Insurance-Prop.Liab.Malpractice			200,614	200,614		200,614	26,089	226,703			26
27	Other (specify):* Bad Debts			3,415	3,415		3,415	(3,415)				27
28	**TOTAL General Administration**	213,450	4,466	1,751,363	1,969,279	10,996	1,980,275	(9,545)	1,970,730			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,194,281	695,790	2,080,388	6,970,459	(31,772)	6,938,687	(65,084)	6,873,603			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME #0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			382,141	382,141		382,141	23,736	405,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			200,429	200,429		200,429	7,818	208,247			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,695	7,695		7,695	9,051	16,746			35
36	Other (specify):*											36
37	**TOTAL Ownership**			590,265	590,265		590,265	40,605	630,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			927	927	31,772	32,699		32,699			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,287	101,287		101,287		101,287			42
43	Other (specify):* **Non Program Exp**	56,033	4,684	54,862	115,579		115,579	(115,579)				43
44	**TOTAL Special Cost Centers**	56,033	4,684	157,076	217,793	31,772	249,565	(115,579)	133,986			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,250,314	700,474	2,827,729	7,778,517		7,778,517	(140,058)	7,638,459			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

BARTON W. STONE CHRISTIAN HOME
MEDICAID RECLASSIFICATIONS
12/31/02

SCH V COST CENTER	DESCRIPTION	INCREASE	DECREASE
22	Employee Benefits	10996	
2	Food Purchase		10996
	Reclass cost of employee meals		
40	Barber & Beauty Shop	31772	
11	Activities		31772
	Reclass Salaries to appropriate Cost Center		
9	Medical Director	1000	
10	Nursing and Medical Records		1000
	Reclass Medical Director Cost		
	Total Reclassifications	43768	43768

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,814)	1		4
5	Telephone, TV & Radio in Resident Rooms	(11,025)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,120)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,415)	27		24
25	Fund Raising, Advertising and Promotional	(115,579)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (147,953)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	91,920		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 91,920		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,033)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		31,772	11-1	41
42	Laboratory and Radiology					42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 31,772		47

STATE OF ILLINOIS

BARTON W. STONE CHRISTIAN HOME

ID# 0000984

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Admin & General Income	$ (15,716)	21	1
2	Activity Income	(1,653)	11	2
3	Maintenance Income	(3,061)	6	3
4	Dietary Income	(1,203)	1	4
5	Nursing Income	(17,381)	10	5
6	Housekeeping Income	(106)	3	6
7	Non Program Related Depreciation	(7,316)	30	7
8	Shared Admin Adjustment (See Adm Adj).	(4,395)	21	8
9	Shared Admin Adjustment (See Adm Adj).	(1,171)	22	9
10	Shared Maintenance Adjustment (See Maint Adj)	(25,034)	6	10
11	Shared Maintenance Adjustment (See Maint Adj)	(6,670)	22	11
12	Development Travel Expense included in Pat. Rel.	(319)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(84,025)		49

BARTON STONE
ADJUSTMENT for SHARED ADMINSTRATIVE TIME
PERIOD ENDING 12/31/02

Ratio of Non-Program Expense to Total Expense

Description	Cost
Total Cost of Operations	7778517
Less Adm. Sals & Benefits	(270,325)
Total Expense	**7508192**

Admin Salaries & Benefits for Above

Administrative Salaries	213,450	0.05022
Total Facility Salaries	4,250,314	
Net Employee Benefits	1132522	
Admin portion of Benefits	56875	(C17XB20)
Total Admin	270,325	

Non Program Related Expenses

Amount from CR Line 43	115579
Amount from Shared Maint.	31704
Depreciation Adjustment	7,316
Total Non Program Epense	154599

Elimination Adjustment for Shared Admin Time

Adj. Expense of Operations	7508192	Ratio
Non Program Related Exp.	154599	0.020591
Administrative Salaries	213,450	**-4395 Adj. To CR Line # 21**
Administrative Benefits	56875	**-1171 Adj. To CR Line # 22**

BARTON STONE
ADJUSTMENT for SHARED MAINTENANCE STAFF
PERIOD ENDING 12/31/02

Square Footage Allocation Basis

Description	Sq. Feet	Alloc. Ratio	Non Program
Nursing Facility	191113	0.843464	
Cottages & Duplexes	30875	0.136265	0.136265
Asa Talcott Historical Bldg.	3335	0.014719	0.014719
Development House	1258	0.005552	0.005552
Total Square Feet	**226581**	**1**	**0.156536**

Maintenance Salaries	159,924	Non-Allow.	-25034	Adjustment to Cost Report Line 6

Maintenance Salaries	159,924	0.037626
Total Facility Salaries	4,250,314	

Net Employee Benefits	1132522			
Maint portion of Benefits	42612	Non-Allow.	-6670	Adjustment to Cost Report Line 22

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(17,017)	0	0	0	0	0	0	0	0	0	0	(17,017)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(106)	0	0	0	0	0	0	0	0	0	0	(106)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,025)	10,337	0	0	0	0	0	0	0	0	0	(688)	5
6	Maintenance	(28,095)	9,401	0	0	0	0	0	0	0	0	0	(18,694)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(56,243)	19,738	0	0	0	0	0	0	0	0	0	(36,505)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(17,381)	0	0	0	0	0	0	0	0	0	0	(17,381)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,653)	0	0	0	0	0	0	0	0	0	0	(1,653)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,034)	0	0	0	0	0	0	0	0	0	0	(19,034)	16
	C. General Administration													
17	Administrative	0	(272,375)	0	0	0	0	0	0	0	0	0	(272,375)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,183	0	0	0	0	0	0	0	0	0	25,183	19
20	Fees, Subscriptions & Promotions	0	1,579	0	0	0	0	0	0	0	0	0	1,579	20
21	Clerical & General Office Expenses	(20,111)	165,775	0	0	0	0	0	0	0	0	0	145,664	21
22	Employee Benefits & Payroll Taxes	(7,841)	45,125	0	0	0	0	0	0	0	0	0	37,284	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(319)	30,765	0	0	0	0	0	0	0	0	0	30,446	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	26,089	0	0	0	0	0	0	0	0	0	26,089	26
27	Other (specify):*	(3,415)	0	0	0	0	0	0	0	0	0	0	(3,415)	27
28	**TOTAL General Administration**	(31,686)	22,141	0	0	0	0	0	0	0	0	0	(9,545)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(106,963)	41,879	0	0	0	0	0	0	0	0	0	(65,084)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,316)	31,052	0	0	0	0	0	0	0	0	0	23,736	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,120)	9,938	0	0	0	0	0	0	0	0	0	7,818	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	9,051	0	0	0	0	0	0	0	0	0	9,051	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,436)	50,041	0	0	0	0	0	0	0	0	0	40,605	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(115,579)	0	0	0	0	0	0	0	0	0	0	(115,579)	43
44	**TOTAL Special Cost Centers**	(115,579)	0	0	0	0	0	0	0	0	0	0	(115,579)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(231,978)	91,920	0	0	0	0	0	0	0	0	0	(140,058)	45

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A				National Benevolent Association	St. Louis, MO	Divisioin of Social & Health Services of the Christian Church (Disciples of Christ).

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Supportive Services	$ 297,274	National Benevolent Association	100.00%	$	$ (297,274)	1
2	V		5	Utilities		National Benevolent Association	100.00%	10,337	10,337	2
3	V		6	Repairs & Maintenance		National Benevolent Association	100.00%	9,401	9,401	3
4	V		17	Administrative		National Benevolent Association	100.00%	24,899	24,899	4
5	V		19	Professional Fees		National Benevolent Association	100.00%	25,183	25,183	5
6	V		20	Dues & Subscriptions		National Benevolent Association	100.00%	1,579	1,579	6
7	V		21	Clerical		National Benevolent Association	100.00%	165,775	165,775	7
8	V		22	Employee Benefits		National Benevolent Association	100.00%	45,125	45,125	8
9	V		24	Seminars		National Benevolent Association	100.00%	30,765	30,765	9
10	V		26	Insurance		National Benevolent Association	100.00%	26,089	26,089	10
11	V		30	Depreciation		National Benevolent Association	100.00%	31,052	31,052	11
12	V		32	Interest Expense		National Benevolent Association	100.00%	9,938	9,938	12
13	V		35	Equipment Rental		National Benevolent Association	100.00%	9,051	9,051	13
14	Total				$ 297,274			$ 389,194	$ * 91,920	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: National Benevolent Association
Street Address: 11780 Borman Drive
City / State / Zip Code: St. Louis, MO 63146-4157
Phone Number: (314) 993-9000
Fax Number: (314) 993-9018

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	153,803,006	28	$ 212,518	$	7,481,242	$ 10,337	1
2	6	Repairs & Maint.	Direct Cost	153,803,006	28	193,264		7,481,242	9,401	2
3	17	Administrative	Direct Cost	153,803,006	28	511,893	511,893	7,481,242	24,899	3
4	19	Professional Fees	Direct Cost	153,803,006	28	517,721		7,481,242	25,183	4
5	20	Dues & Subscriptions	Direct Cost	153,803,006	28	32,465		7,481,242	1,579	5
6	21	Clerical	Direct Cost	153,803,006	28	3,408,074	2,994,546	7,481,242	165,775	6
7	22	Employee Benefits	Direct Cost	153,803,006	28	927,708		7,481,242	45,125	7
8	24	Seminars	Direct Cost	153,803,006	28	632,482		7,481,242	30,765	8
9	26	Insurance	Direct Cost	153,803,006	28	536,344		7,481,242	26,089	9
10	30	Depreciation	Direct Cost	153,803,006	28	638,386		7,481,242	31,052	10
11	32	Interest Expense	Direct Cost	153,803,006	28	204,304		7,481,242	9,938	11
12	35	Equipment Rental	Direct Cost	153,803,006	28	186,066		7,481,242	9,051	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,001,225	$ 3,506,439		$ 389,194	25

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996 Series Bonds		X	Facility Refinancing & Renovat	$20,717.00	5/1996	$ 3,035,000	$ 2,650,000	5/2021	Variable	$ 163,574	1
2	1998 Refinancing Bonds		X	Refinance Promissory Note	$5,949.00	2/1998	944,834	786,032	5/2015	Variable	36,855	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$26,666.00		$ 3,979,834	$ 3,436,032			$ 200,429	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,979,834	$ 3,436,032			$ 200,429	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BARTON W. STONE CHRISTIAN HOME COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0000984

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 191,113 B. General Construction Type: Exterior Brick Frame N/A Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ASA Talcott House which is a historical structure, another house which is used by Development and some cottages and duplexes.
All costs related to the above locations have been reported on cost report line # 43 and adjusted to zero.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1964	1964	$ 369,315	$		$	$	$	4
5			1969	1966	2,236						5
6			1970	1969	491,576						6
7			1990	1970	57,659						7
8	33		1998	1998	2,473,810						8
	Improvement Type**										
9	Various			1970	639,983						9
10	Various			1971	14,949						10
11	Various			1973	22,161						11
12	Various			1976	12,870						12
13	Various			1977	1,661						13
14	Various			1975	154,002						14
15	Various			1991	1,056,337						15
16	Various			1974	457,060						16
17	Various			1978	3,656						17
18	Various			1979	14,306						18
19	Various			1980	8,268						19
20	Various			1981	4,577						20
21	Various			1982	20,064						21
22	Various			1983	512						22
23	Various			1984	2,668,941						23
24	Various			1985	110,535						24
25	Various			1986	29,302						25
26	Various			1987	83,683						26
27	Various			1988	38,037						27
28	Various			1989	32,575						28
29	Various			1992	75,906						29
30	Hockenhull Heating System			1993	181,603						30
31	Hockenhull Shelving Units			1994	24,080						31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Hockenhull dining Room Expansion	1995	$ 23,635	$		$	$	$	37
38	Carpet, Floor Covering Base	1996	3,945						38
39	Hockenhull Covering and Rails	1996	3,390						39
40	Alarm System	1996	32,351						40
41	Redecorating Hockenhull 1 East Hall	1996	3,502						41
42	Hockenhull 1 and II - Tile	1996	3,474						42
43	Hockenhall 1 - Wallpaper	1996	3,240						43
44	Handrails - Younkin Parking Lot	1996	3,658						44
45	Boiler/HVAC Repairs	1996	14,544						45
46	Electrical Repairs	1996	1,982						46
47	Asbestos Abatement	1996	1,000						47
48	Shower Tile Repair	1996	788						48
49	Masonry - Window/Garage/Boiler Room	1996	640						49
50	Patch Walkway Roof Between Hutton/Younkin	1996	523						50
51	Water Heater Repair	1996	748						51
52	Disposal for Hutton Kitchen	1996	865						52
53	Hockenhull Wallpaper and Carpet	1997	8,184						53
54	Carpet for Younkin	1997	4,239						54
55	Window Treatments-Pleated Shades	1997	5,948						55
56	Elevator Logic Controls	1997	17,430						56
57	Wanderguard - Resident Security System	1997	9,998						57
58	Hockenhull Water Heater	1997	2,770						58
59	Tile Replacement (Hockenhull and Exam Room)	1997	1,224						59
60	Plumbing - Condensing Unit in Younkin	1997	5,530						60
61	Sanitizer	1997	6,319						61
62	Community Room, Activity Room, PT Room	1997	8,791						62
63	Younkin Basement Stair Door	1997	675						63
64	Parking and Site Work	1997	44,048						64
65	Installation of 2 Auto Doors with Push Buttons	1997	4,943						65
66	Parking Lot Lights, Work South and East	1997	50,939						66
67	Plumbing Work	1997	12,010						67
68	Landscaping	1997	2,206						68
69	Line Work/Cable Run/Electric	1997	3,090						69
70	TOTAL (lines 4 thru 69)		$ 9,336,293	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,336,293	$		$	$	$	1
2	Sidewalks	1997	2,758						2
3	Parking Lot and Site Work	1998	101,675						3
4	Additional Building Change Order Costs	1998	153,825						4
5	Boiler/HVAC Repairs	1998	1,391						5
6	Reroofing North and East	1998	34,646						6
7	Blinds for Dining Room	1998	1,650						7
8	Foundation Leakage	1998	7,770						8
9	Generator Load Panel	1998	5,541						9
10	A/C Compressor	1998	4,594						10
11	Electrical	1998	4,486						11
12	Plumbing and Heating	1998	18,732						12
13	Tree Stump Removal	1998	700						13
14	Cove Base	1998	715						14
15	Carpet-Dining Room-Hockenhull	1999	8,097						15
16	Kitchen Remodeling - Hockenhull	1999	2,367						16
17	Emergency Outlets and Lighting-Hockenhull	1999	6,104						17
18	Replace Employee Breakroom Floor-Hockenhull	1999	1,099						18
19	Window Covering - Hutton	1999	4,229						19
20	Carpet and Cove Base - Hutton	1999	15,818						20
21	Sewer Repair - Hutton	1999	5,314						21
22	Casework Replacement Kitchen - Hutton	1999	7,622						22
23									23
24									24
25									25
26									26
27									27
28									28
29	Smokers Shelter	1999	6,710						29
30	Renovation Younkin (Life Safety, Duct Work, Dampers)	1999	18,107						30
31									31
32	Casework Replacement Utility Room - Younkin	1999	22,988						32
33	Window Project Hockenhull Bldg.	2000	15,000						33
34	TOTAL (lines 1 thru 33)		$ 9,788,231	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,788,231	$		$	$	$	1
2	Window Enlargement Hockenhull Proj. Metal Blinds	2000	8,159						2
3	Aluminum Windows Hockenhull Bldg.	2000	12,564						3
4	Hockenhull-Tuck Painting, Caulking, Sealing Masory/EL	2000	12,084						4
5	Over Bed Lights for Hutton Bldg.	2000	6,146						5
6	Carpets/Blinds/Cabinets/Elevator Re-Worrking Younkin	2000	21,640						6
7	Hockenhull Dining Room Remodeling Project- Carpets	2001	7,910						7
8	Upgrade Fire Alarm System per IDPH Survey	2001	2,503						8
9	Construction of Pavillion	2002	15,899						9
10	Generator Application, Inspection	2002	3,687						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,878,823	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,878,823	$		$	$	$	1
2	Allocated from NBA	1984	299						2
3	Allocated from NBA	1985	1,042						3
4	Allocated from NBA	1996	21,107						4
5	Allocated from NBA	1994	2,347						5
6	Allocated from NBA	1995	24						6
7	Allocated from NBA	1997	4,510						7
8	Allocated from NBA	1998	74,329						8
9	Allocated from NBA	1999	70,834						9
10	Allocated from NBA	2000	9,750						10
11	Allocated from NBA	2001	2,932						11
12	Allocated from NBA	2002	2,273						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,068,270	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,720,665	$ 400,399	$ 400,399	$		$	71
72	Current Year Purchases	100,910						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,821,575	$ 400,399	$ 400,399	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Van With Lift	2002 Chevy Venture	2002	$ 36,450	$ 911	$ 911	$	10	$ 911	76
77	Facility Maintenance	1996 Dodge Truck	1998	13,107	2,621	2,621		5	13,107	77
78	Patient Services	1995 Chevy Lumina	1998	5,095	1,019	1,019		5	4,840	78
79	Capitalized Vehicle Rep.	Dodge Truck & Van	2000	3,179	927	927		2	3,179	79
80	TOTALS			$ 57,831	$ 5,478	$ 5,478	$		$ 22,037	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,947,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 405,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 405,877	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 22,037	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage/Duplex Improvements	$ 55,671	$ 3,718	$ 26,165	86
87	Development Building Equip./Improv.	39,263	1,805	36,359	87
88	Grove Development Office	18,327	991	14,418	88
89	Development Vehicle	8,019	802	1,403	89
90					90
91	TOTALS	$ 121,280	$ 7,316	$ 78,345	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

National Benevolent Association
Summary of Fixed Assets from Home Office Cost Report
12/31/02

Building & Improvements	Year Acq.	Total Cost	Yearly Summary	Alloc. %	Alloc. To Barton Stone	Year
Various	1984	4,962.21	4,962.00	0.04626	230	1984
Various	1985	17,289.00	17,289.00	0.04626	800	1985
Various	1993	886.00				
Various	1993	1,963.66				
Various	1993	317,629.09				
Various	1993	3,038.00				
Various	1993	26,763.90	350,281.00	0.04626	16204	1993
Various	1994	44,977.00				
Various	1994	1,170.00	46,147.00	0.04626	2135	1994
Various	1995	480.00	480.00	0.04626	22	1995
4151-53 Shaw Ave. - Purchase & renovation	1997	59,574.00				
4151-53 Shaw Ave. - Purchase & renovation	1997	12,413.34				
4151-53 Shaw Ave. - Purchase & renovation	1997	14,568.61				
Renovation - Shaw Phase II electrical work/repair	1997	2,118.00	88,674.00	0.04626	4102	1997
Replce Halsey Taylor Water Cooler	1998	1,677.20				
1998 Purchase of D.H.E. portion of Beasley Bldg.	1998	1,352,226.00				
Closing Costs - Building Purchase	1998	1,159.00				
Legal Service Regarding Bldg. Purchase from DHE	1998	2,745.00				
Seal entire roof system with Whie rubberized sealant	1998	8,100.00				
Roof repair & seal coating vulcanizing rubber roof seals	1998	13,129.00				
Roofing Repair - New Addition	1998	8,049.00				
Paint Exterior - Central Office	1998	2,950.00				
Repair Roof - Wind damage primarily copper system	1998	777.00				
Roof Repair - Repair flashing new wing of bldg.	1998	3,824.00				
Replace condensor plus labor- west wing	1998	6,916.00				
Renovation - Olive Branch II plus construction costs	1998	23,032.00				
Renovation - Olive Branch II plus construction costs	1998	36,852.52	1,461,438.00	0.04626	67606	1998
1999 NBA fixed asset addition - Per Home office C/R	1999	1,431,734.00	1,431,734.00	0.04626	66232	1999
2000 NBA fixed asset addition - Per Home office C/R	2000	210,772.00	210,772.00	0.04626	9750	2000
2001 NBA fixed asset addition - Per Home office C/R	2001	68,609.57	68,610.00	0.042738	2932	2001
2002 NBA fixed asset addition - Per Home office C/R	2002	46,728.00	46,728.00	0.048642	2273	2002
TOTALS		3,727,113.10	3,727,115.00		172286	

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 76,766	$	1
2	Cash-Patient Deposits	15,781		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	352,402		3
4	Supply Inventory (priced at)	33,179		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 478,128	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 478,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,454	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,781		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,827		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,525		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,611		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 368,198	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 368,198	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 109,930	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 478,128	$	48

***(See instructions.)**

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,620	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	104,310	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 104,310	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 109,930	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,266,239	1
2	Discounts and Allowances for all Levels	(818,642)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,447,597	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,123	12
13	Barber and Beauty Care	41,032	13
14	Non-Patient Meals	15,814	14
15	Telephone, Television and Radio	11,025	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	39,119	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 109,113	23
	D. Non-Operating Revenue		
24	Contributions	256,950	24
25	Interest and Other Investment Income***	2,120	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 259,070	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Trust and Transfer Income	1,067,047	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,067,047	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,882,827	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,791,496	31
32	Health Care	3,209,684	32
33	General Administration	1,969,279	33
	B. Capital Expense		
34	Ownership	590,265	34
	C. Ancillary Expense		
35	Special Cost Centers	116,506	35
36	Provider Participation Fee	101,287	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,778,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	104,310	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 104,310	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,695	2,097	$ 45,610	$ 21.75	1
2	Assistant Director of Nursing	7,925	8,445	158,051	18.72	2
3	Registered Nurses	17,175	18,385	302,281	16.44	3
4	Licensed Practical Nurses	38,242	41,251	570,349	13.83	4
5	Nurse Aides & Orderlies	142,041	151,020	1,396,724	9.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,513	5,048	55,286	10.95	8
9	Activity Director	2,461	2,719	39,897	14.67	9
10	Activity Assistants	13,061	14,367	91,463	6.37	10
11	Social Service Workers	7,639	8,327	130,892	15.72	11
12	Dietician					12
13	Food Service Supervisor	1,884	2,160	30,749	14.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	49,318	53,925	457,290	8.48	15
16	Dishwashers	2,754	2,796	19,645	7.03	16
17	Maintenance Workers	14,324	15,976	159,924	10.01	17
18	Housekeepers	29,677	32,670	295,485	9.04	18
19	Laundry	11,390	12,614	113,089	8.97	19
20	Administrator	1,920	2,080	80,455	38.68	20
21	Assistant Administrator	1,904	2,160	51,113	23.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,387	7,028	81,882	11.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,726	6,582	82,324	12.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Page 20 Supp.	7,053	7,541	87,805	11.64	33
34	TOTAL (lines 1 - 33)	367,089	397,191	$ 4,250,314 *	$ 10.70	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,280	1-3	35
36	Medical Director		1,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,604	10-3	38
39	Pharmacist Consultant		1,924	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	2,595	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	$ 13,403		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,184	38,186	10-3	51
52	Nurse Aides	96	1,725	10-3	52
53	TOTAL (lines 50 - 52)	1,280	$ 39,911		53

Barton W. Stone Christian Home
Supplemental Salary Schedule for Line 33, Page 20
Period Ended 12/31/02

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accured	Reporting Period Total Salaries	Average Hourly Wage
Beauticians	3088	3303	31772	9.62
Fundraisers	3965	4238	56033	13.22
	7053	7541	87805	11.64

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Hannel	Administrator		$ 80,455
Mignon Goodpasture	Asst. Administrator		51,113
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,568

B. Administrative - Other

Description	Amount
Natioinal Benevolent Association - Central Office Cost	$ 297,274
TOTAL (agree to Schedule V, line 17, col. 3)	$ 297,274
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Rammelkamp Law Of.	Legal Fees	$ 13,494
Pranschke & Holderle	Legal Fees	5,152
Grace & Company LLP	Audit	5,426
NBA Cost Report Preparation	Accounting	1,500
Ceridian	Payroll Services	8,315
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,887

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,956
Unemployment Compensation Insurance	20,535
FICA Taxes	324,837
Employee Health Insurance	408,624
Employee Meals	10,996
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	2,461
Pension Plan	211,037
Retired Employee Benefits	30,263
Employee Physicals	1,971
Employee Recognition	11,738
Allocated from NBA	45,125
Shared Admin & Maint. Adj.	(7,828)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,177,715

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	500
(Indicate # of checks performed)	
Help Wanted Ads	2,581
Dues & Subscriptions	8,581
Fees & Licenses	5,000
Allocated from NBA	1,579
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,231
In-State Travel	
Mileage Reimbursement	1,619
Housing Meals/Other	3,785
Seminar Expense	
Registration-Conference	1,923
Vocational Training	3,973
Allocated From NBA	30,765
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 43,296

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME # 0000984 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BARTON W. STONE CHRISTIAN HOME **#** 0000984 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network-$7,563**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **120 Months**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **85,343** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **101,287**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,996** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,814**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Mare & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.